

APPLICATION FOR LICENSE TO ENGAGE IN A CONTROLLED SUBSTANCE ACTIVITY

NAME _____ D/B/A _____ Street _____ City _____ State _____ ZipCode _____ (when using a P.O. Box you must also use a street address)	County:	Who should we contact? Name: _____ Title: _____ Tel. #: _____
	Application _____ Date: ____/____/____	

<input type="checkbox"/> CLASS 1 Manufacturer	\$1200
<input type="checkbox"/> CLASS 1a Manufacturer(out of state)	\$1200
<input type="checkbox"/> CLASS 2 Distributor	\$1200
<input type="checkbox"/> CLASS 2a Distributor (out of state)	\$1200
<input type="checkbox"/> CLASS 3 Institutional Dispenser	\$100
<input type="checkbox"/> CLASS 3a Institutional Dispenser - limited	\$100
<input type="checkbox"/> CLASS 3b Limited to obtaining official RX's	\$100
<input type="checkbox"/> CLASS 4 Researcher (Schedules II-V)	\$40

<input type="checkbox"/> CLASS 5	Instructional Activities (Schedules II-IV)	\$40
<input type="checkbox"/> CLASS 7	Research and Instructional (Schedule I)	\$40
<input type="checkbox"/> CLASS 8	Analytical Laboratory	\$40
<input type="checkbox"/> CLASS 9	Importer	\$1200
<input type="checkbox"/> CLASS 9a	Importer-broker	\$1200
<input type="checkbox"/> CLASS 10	Exporter	\$1200
<input type="checkbox"/> CLASS 10a	Exporter-broker	\$1200

A) Federal DEA license ? Print registration number in the boxes provided and expiration date. Registration Number () () () () () () () () Activity _____ Expiration Date _____

B) Already licensed by the Department to engage in controlled substance activity? Please enter license number(s) and date. License No. () () () () () () () () Date Issued. _____

C) Registered with N.Y.S. Board of Pharmacy? If yes: License No. _____ Exp. Date _____

D) Registered with another State Board of Pharmacy? If yes: License No. _____ State of: _____

E) Licensed by any other NYS agency? Please give agency and license number..
License No. _____ Activity _____ Agency _____
License No. _____ Activity _____ Agency _____
Are any required licenses pending? Agency _____ Licensed activity. _____

Continued ➡

5) **PROPOSED STORAGE OF CONTROLLED SUBSTANCES AND/OR OFFICIAL PRESCRIPTIONS:**

Please describe location of each site of controlled substance storage. Indicate means of security. This proposal must comply with the specific regulatory requirement for the specific license.

6) **If other than the applicant, who will be supervising the controlled substance activity?**

Print Name:	Title:
Signature:	Type of professional License and Number (if any) :

7) **ACKNOWLEDGEMENT BY APPLICANT**

The applicant fully understands that the license to be issued hereon shall be subject to the following stipulations and conditions:

1. That the applicant is knowledgeable concerning all laws and regulations, both State and Federal, regarding the licensed activity and shall comply with such requirements.
2. That the registrant shall be under a continuing duty to inform the New York State Department of Health of any changes, such as change of name, change of address and of substantial changes to the physical security and means of recordkeeping regarding the controlled substances.
3. That the license privilege herein applied for, if granted, shall not be transferred. Change in name or ownership in institutional and business registrants shall be immediately reported to the Department.
4. That any license so issue as a result of this application for license shall be promptly returned to the Department upon revocation or suspension of this license or the Federal license for this activity. License shall be promptly returned to the Department when the activity for which the applicant is licensed has been discontinued.
5. Licensee shall promptly report to the Department each incident or alleged incident of theft, loss or possible diversion of controlled substances or Official Prescriptions. Such notification shall be by first contacting the local regional office of the Bureau of Controlled Substances and then shall be reported on forms provided by the department. Reporting of such incident to other government agencies does not relieve the licensee of this responsibility.

8)

Has the applicant ever been convicted of a felony or a crime connected with controlled substances? Yes <input type="checkbox"/> No <input type="checkbox"/>	Has the applicant ever had a state or federal professional license or controlled substance registration revoked, suspended, denied, restricted or placed on probation? Yes <input type="checkbox"/> No <input type="checkbox"/>	If the applicant is a partnership, stockholder, proprietor or corporation (other than a corporation whose stock is owned and traded by the public) has any officer been convicted of a felony or a crime involving controlled substances under state or federal law, or has a state or federal professional license or controlled substance registration been revoked, suspended, denied, restricted or placed on probation? Yes <input type="checkbox"/> No <input type="checkbox"/>
Applicants who answer "Yes" to any of the above questions are required to submit a statement explaining such response and include such statement with this application.		

9) **Applicant signature** (must be an original signature in ink.)

Under the penalties of perjury, I affirm that the statements herein are true and that I have become knowledgeable regarding the requirement of the licensed activity for which I am applying.

Date

Signature and Title of Officer or Applicant

Federal I.D. number
Return completed application to:

Type or Print Above Name
New York State Department of Health
Bureau of Controlled Substances
433 River Street, Suite 303
Troy, NY, 12180-2299

Telephone number

Telephone: (518) - 402-0708

Fee must be included. Check or money order payable to: New York State Department of Health
State, County, and Municipal Agencies are EXEMPT FROM FEES.